Maricopa County's Authorization to Use and Disclose Protected Health Information

Identity of patient authorizing the release/disclosure of protected health information (PHI). Please Print Legibly

Name of patient:_____ Employee ID #:__ __ __ __ __ __ __ __ __
Alternative ID # or Social Security Number: __ __ __ __ __ __ __ __ __ Date of Birth __/__/____

Name of person/organization authorized to receive the protected health information. (PHI):

☐ Employee Health Initiatives Benefits Office ☐ County Department Liaison:_____
☐ Other:_____

PHI to be disclosed is regarding ☐ Self ☐ Spouse:_____ ☐ Dependent_____ ☐ Other_____
PHI to be disclosed is from date ___/___/_____ through date ___/___/_____

Specific Description of the protected health information to be disclosed:
☐ Claims for date the service beginning ___/___/_____ and ending ___/___/_____
Name of Medical Provider:_____ Amount of Charges: $_____
☐ Authorization/Pre-certification/Referrals from referring physician _____
Date of referral/admission_____ Type of Service:_____
☐ Other:_____

The purpose of the disclosure of PHI is:
☐ Being billed incorrectly ☐ Claim not paid/paid incorrectly ☐ Eligibility/Enrollment/Insurance Coverage
☐ Collections ☐ Continued Patient Care ☐ The disclosure is at the patient's request
☐ Other:_____

Provide a brief description of what action you are requesting to be taken:

With respect to all information other than HIV and AIDS-related information, this authorization will expire on the earlier of 365 days after the date of this signature or the date when I no longer am employed by Maricopa County or on following date: ____/____/_____.
With respect to HIV and AIDS-related information, this authorization will expire 6 months from the date of signing.

I understand that the covered entity(the provider, health plan or health care clearinghouse) may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that after this information is disclosed, the HIPAA federal law might not protect it and the recipient might re-disclose it.

SIGNATURE

I hereby release anyone disclosing or receiving the records or information specified above pursuant to this authorization from any and all liability arising from that disclosure. I understand that I have the right to revoke this authorization at any time by notifying Maricopa County's Employee Health Initiatives Department in writing at 301 W. Jefferson, Suite 201, Phoenix, AZ 85003, except to the extent that action has been taken in reliance upon it.

Patient's Signature: _____ Date: __/__/____

If patient is unable to give consent because of physical condition or age, complete the following:
Patient is a minor (___ years of age), or is unable to give consent because_____
_____

Signature of Parent/Guardian/Power of Attorney: _____
Relationship to Patient::_____ Description of Authority to Act for Patient:_____

Prohibition of Redisclosure: If the information disclosed relates to substance abuse treatment, the confidentiality of these records is protected by federal law. Federal regulations (42 CFR Part 2) prohibit any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rule restricts any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient records.

Please note, you are entitled to receive a copy of this authorization form.

You may fax a copy of this form to Employee Health Initiatives at 602-506-2354, however, a signed original authorization form is required for our records.

For Office Use: ☐ Requested original faxed form on __/__/____ Name of requester: